Records Release Authorization

Please circle below which physician you have chosen as your child's doctor so that medical records can be reviewed by that physician prior to your first visit.

Kolby Gerling, D.O. Abby Kushnir, M.D. Jennifer Panasci, M.D Lori Payne, PNP

Parent/Guardian: _____Telephone Number: _____

I hereby authorize the use of disclosure of my child/children's health information as described below.

Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____
Patient's Name: _____ DOB: _____

Please do not send full copies of medical records.

WE ONLY NEED THE FOLLOWING INFORMATION RELEASED.
° Growth Grid, Vaccine Record, Medication Record, Problem List (ONLY)

WingHaven Pediatrics is authorized to obtain medical records from the following

_____
Doctor or Medical Center (print)

Address:

_____

_____

Telephone Number: _____ Fax Number: _____

This authorization shall be in force and effect for 90 days from date of signed (unless otherwise noted) at which time authorization to use or disclose expires. I understand I have the right to revoke this authorization at anytime, in writing, or by mailing notification to this practice.

Parent/Guardian Signature: _____ Date: _____

Parent e-mail address: _____

Office use only:

WingHaven Pediatrics
5551 WingHaven Blvd.
Suite 240, O'Fallon, MO 63368
Telephone: 636-561-5561 Fax: 636-561-5557